INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only**)**

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VI WITHDRAWAL OF CONSENT

I,_____WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

DH 3204, 11/08 Original to file Copy to client DOB: _____

Department of Health in Clay County / Patient Contact Information

In general, the HIPPA privacy rule gives individuals the rights to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means.

I wish to be contacted in the following manner: (INITIAL ALL THAT APPLY)

INITIALS		INITIALS	
☐	Home Telephone Provide #	☐	Written Communication
☐	May leave a detailed message.	☐	Mail to my home address
☐	May leave a message with a call-back number only.		Provide Home Address:
☐	Cell Telephone Provide # (Confidentiality cannot be ensured) May leave detailed message	☐	Emergency Contact Information:
☐	Work Telephone Provide #		Name: _____ Phone: _____
☐	May leave a detailed message	☐	Emergency Contact Information:
☐	May leave a message with a call-back number only.		Name: _____ Phone: _____
☐	School Name:		
☐	May contact me through school nurse		

Note: Your wishes will be taken into consideration when we attempt to contact you; however, we are informing you that it is our our professional obligation to contact you regarding abnormal or suspicious lab results.

_____ _____
Patient Signature Date

_____ _____
Print Patient Name Date of Birth

_____ _____
Witness / Clay CHD Staff Signature Date

I revoke the above request for alternate means of communication effective _____.

_____ _____
Patient Signature Date

Florida Department of Health in Clay County
Registration/Eligibility

Name:_____
Last First Middle Initial

Address:_____

City:_____ Zip Code:_____

Home Phone:_____ SSN:_____

Source of Income:_____

Total Monthly Amount:_____

I further acknowledge that I was informed of the eligibility screening offered by the Florida Department of Health in Clay County that provides financial assistance.

_____ _____
Date Signature (Client, Parent, or Guardian)

_____ _____
Date Employee Signature (DOH-Clay)

Patient Demographic Information Sheet

Marital Status:	Divorced	Married	Separated	Single	Widowed
Estado Civil:	Divorciado	Casado	Separado	Soltero	Viudo

Primary Language OTHER THAN English_____

Race/Ethnicity(Raza/Etniciada) ☐ American/Indian/Alaskan Native ☐ Asian☐Black/African American☐Haitian ☐Hispanic
☐White ☐Unknown ☐Other_____

☐Check this box if you are a migrant worker. (Marque aqui' si es usted unmigrante.

Are you a veteran? Yes/No
Are you a college student? Yes/No
Are your pregnant(¿Esta usted embarazada?) Yes/No Due Date (fecha para dar a luz)_____

Telephone Type (Tipo de Tel): ☐Cell ☐Home ☐Work ☐Other

Telephone Number (Numero de teléfono): (_____)_____

Does anyone in your family have health insurance or Medicaid. (En su familia alguien tiene Medicaid o seguro medico)? Yes/Si/No
If yes who_____

Earned Income (Ingresos Ganados)

Employer (Empleo):_____Income (Ingreso): $_____
Frequency (Frecuencia): ☐Weekly (Semanal)☐ Bi-Weekly (Quincerial) ☐ Monthly (Mensual)

Social Security Annuity (Anualidad del Seguro Social): $_____ (NOT SSI)
Public Assistance (Asistencia Publica): $_____Alimony: $_____Veterans Benefit:$_____
Workers Comp (Compensación de trabajo): _____Financial Aid/Grants $_____ (Not student loans)
Child Support _____(Pension Alimenticia)$_____Other income (Otro ingreso no devengado):_____
Unemployment (Desempleo): $_____

Monthly Income Deductions (Deducciones de Ingresos Mensuales)

Child Care Expense Paid (Gastos por cuido de niño pagado) $_____
Child Support Expense Paid (Gastos de manutención pagado) $_____

List all Personal and Business Assets

Car(s)_____Properties_____Bank Account_____
Stocks_____Bonds_____401K_____
Other_____

DO NOT WRITE BELOW THIS LINE

I certify that the above information is a true statement of my financial situation._____
I further acknowledge I was given the sliding fee scale percentage_____
I understand that labs, medicine and other services are not included in the doctor's visit fee_____

* * * * *

I understand that failure to complete my Social Service Assessment will result I being charged 100% for services

_____ _____
Client's Signature *Date*

Florida HEALTH

HOUSEHOLD DATA SHEET

Name: _____

ID #: _____

Date of Birth: _____

FAMILY NAME: _____

English Speaking: ☐ Yes ☐ No If no, specify: _____

Family Is: ☐ Migrant Farmworker ☐ Temporary Resident ☐ Permanent Resident

Address (enter month & year when updating): _____ Lot/Apt _____ City: _____

County: _____ Zip: _____ Telephone No.: _____

Work Phone: _____ Backup Phone: _____ Best Time to Call: _____

Directions to Home (enter month & year when updating): _____

_____

_____

AVAILABLE TRANSPORTATION: ☐ Self ☐ Bus ☐ Taxi ☐ Walk ☐ None ☐ Volunteer ☐ Other: _____

COMMUNITY SERVICES (check those used): (enter month & year when updating)

☐ AFDC	☐ Meals On Wheels	☐ Vocational Rehabilitation
☐ Church	☐ Senior Services	☐ County Social Services
☐ Day Care	☐ School Lunches	☐ Medicaid
☐ Food Stamps	☐ Children's Medical Services	☐ Other: _____

Social Worker: _____ Phone No.: _____ Agency: _____

Persons Living In Home *	Date of Birth	Relationship To Client
Children (under 18) Not Living In Home *	**Date of Birth**	**Comments**

* Enter Month and Year When Updating

LIVING QUARTERS: (check one) ☐ Apartment ☐ House ☐ Mobile Home ☐ Car ☐ Camper ☐ Temporarily without shelter ☐ Other: _____

Number of Rooms: _____ Method to Heat: _____ Method to Cool: _____

CHECK the working things you have: ☐ Refrigerator ☐ Cooking Stove ☐ Hot Plate ☐ Fan ☐ Indoor Toilet

☐ Water Inside for Drinking ☐ Water Inside for Bathing

Date: _____ Name & Title of Person Reviewing: _____

DH 3058, 10/96 (Replaces HRS-H Form 3058 which may be used)
(Stock Number: 5744-000-3058-5)

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:
Person/Facility: Florida Department of Health in Clay County Phone #: 904-272-3177
Address: P.O. Box 578 Green Cove Springs, Fl 32043-0578 Fax #: 904-529-2802

INFORMATION MAY BE DISCLOSED TO:
Person/Facility: _____ Phone #: _____
Address: _____ Fax #: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Records(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of tests(s)) _____

_____ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

_____ HIV test results for non-treatment purposes _____ Substance Abuse Service Provider Client Records
_____ Psychiatric, Psychological or Psychotherapeutic notes _____ Early Intervention _____ WIC

PURPOSE OD DISCLOSURE:
_____ Continuity of Care _____ Personal Use _____ Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____
Client / Representative Signature Date

_____ _____
Printed Name Representative's Relationship to Client

_____ _____
Witness (optional) Date

Client Name: _____
ID#: _____
DOB: _____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Florida Department of Health in Clay County Phone #: 904-272-3177

Address: P.O. Box 578 Green Cove Springs, Fl 32043-0578 Fax #: 904-529-2802

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Records(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of tests(s)) _____

_____ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

_____ HIV test results for non-treatment purposes _____ Substance Abuse Service Provider Client Records

_____ Psychiatric, Psychological or Psychotherapeutic notes _____ Early Intervention _____ WIC

PURPOSE OD DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

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_____ _____

Client / Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____

FLORIDA DEPARTMENT OF HEALTH IN CLAY COUNTY
BEAR RUN CLINIC

CLINIC OPERATIONS, RULES AND EXPECTATIONS

Welcome to Bear Run Clinic, Florida Department of Health in Clay County (DOH-Clay). In order to serve you more efficiently, we ask that you read and sign this document regarding clinic operating procedures. Your signature indicates that you have read and agree to abide by the following clinic policies.

____ Appointments

Bear Run Clinic is open 8 AM until 5 PM Monday through Friday, except for the first Wednesday morning each moth for staff training and State holidays. The clinic operates on a pre-scheduled basis, so always call the clinic to make an appointment. We will do our best to schedule appointments on a same day-next clinic day basis, except in true emergency situations, if you walk in to receive care without an appointment, we can not guarantee that you'll receive care on that day. By calling ahead at (904)529-2800, or (904)272-3177 option #1, you can schedule an appointment at a mutually convenient time. **PLEASE** do not come to the clinic without an appointment, as this will cause very significant wait time in your care, **if** we are able to see you that day.

Your appointment time is the time you are expected to report to the registration desk. Registration is considered part of your appointment process, so once it is complete you will be taken back for preparation to see your provider. If you need to cancel an appointment, please call as soon as you are aware of the need to cancel so that we may service another client in that appointment time.

Keep track of your appointments and plan ahead so you arrive on time. If you are more than 15 minutes late your appointment may need to be rescheduled for another date. Habitual tardiness or failure to keep appointments is costly for the clinic, is not good for your health care, and could be caused for termination of clinic services.

____ Appointment Check In

The clinic check in staff will ask you about your health insurance coverage, identification and if self-pay, how are your going to pay for the visit to include medications and laboratory services. Please bring your Medicaid, Medicare or other health insurance cards with you for each clinic visit. You are responsible for the charges associated with your visit. If your insurance chooses not to pay DOH-Clay, you are responsible for all charges. Please provide check in staff with current phone numbers, address and insurance information at time of check in.

____ Illness

If you experience illness or medical problems which you feel needs to be evaluated before your scheduled appointment, call the clinic at (904)529-2800 option #4, then option #3, option #4 to leave a detailed message including a phone number where you can be reached for a nurse who will return your call within three (3) business hours.

___ **Emergency Care**

If you experience a life-threatening or urgent problem or illness, report to the nearest hospital emergency room or dial 911 for emergency assistance. If you do visit the emergency room or are released from the hospital, please call the clinic nurse message line at (904)529-2800, option #4, option #3, option #4 and leave a detailed message to assist the clinic staff to obtain copies of your medical records and inform your provider of your hospitalization/emergency room visit.

___ **Special Needs**

If you require accommodations for a disability, please inform the clinic staff when you schedule your appointment. Normally we require a minimum of two business days to obtain interpreters or other support staff to accommodate your disability.

___ **Pharmacy**

DOH-Clay does not have a pharmacy. Patients with health insurance will be provided prescriptions to be filled at a community pharmacy of their choice. Those without insurance may be eligible for very limited medication assistance.

___ **Prescription Refills**

You are expected to monitor the number and timing of your prescription medication refills. **Do not** wait until the day before your medications run out. Ask for refills during your scheduled appointments. If you need a new written prescription or if you need the staff the call your pharmacy to authorize refills, you must provide a minimum of three (3) business days advance notice to process your request.

___ **Medical/Insurance Documents**

Requests for your provider to complete insurance, disability or other health related forms will be completed as quickly as possible but you must give a minimum of three (3) business days of your request.

___ **Laboratory Results**

Only your medical provider is authorized to disclose diagnostic and laboratory test results. You are encouraged to obtain these results during routine appointments.

___ **Confidentiality**

Federal and state regulations govern client confidentiality. Clinic staff cannot discuss your care with anyone but you, except with your written consent. Please inform your relatives and significant others that we will not even acknowledge your participation in our programs without your written permission.

___ **Clinic Conduct**

Our clinical staff will always treat you with respect and we expect the same behavior from you in return. The following behaviors and actions are not appropriate in our clinic and will result in your being asked to leave the clinic:

a. Failure to follow the professional requests and procedures of the clinic staff
b. Using or directing profanity with the clinic
c. Threatening acts or language towards clinic staff, clients or visitors
d. Causing or creating such actions that may disturb fellow clients, staff or visitors.

Health Insurance and Eligibility

The clinic accepts Medicaid; some of the Medicaid HMO's some of the Medicare HMO's, and on a preauthorized basis a limited number of insurance companies. If you do not have any health insurance, you may be eligible for self-pay on a sliding fee scale. Eligibility for sliding fee scale is dependent on your unique circumstances and services desired. Some of the factors in determining your eligibility include your income, residency, family size, services desired. Other factors maybe considered, depending upon your unique situation. Eligibility will assist in determining your financial responsibility for care, medicine and laboratory services which may range from zero to 100% of our charges. Eligibility will need to be re-evaluated on a regular basis. Social Services Department located in the Administration Building in Green Cove Springs is responsible for eligibility determination and determination of your financial status.

Additional DOH-Clay eligibility information and forms are available on our website **http://doh.state.fl.us/chdclay/.**

Financial Responsibility for Clinical Services

Depending on your eligibility determination by DOH-Clay Social Services Department, you may be expected to pay for all or part of your care, medications and laboratory services at the time the service is provided. Co-payments will be collected prior to being seen, and deductibles must be met at the time of your visit. If you have any questions regarding your financial responsibilities, contact the Senior Clerical Supervisor at 904-213-3263 in advance of your clinic visit to resolve any issues. Failure to maintain your financial responsibility may result in turning your account over to a commercial collections agency and/or termination of clinic services.

Concerns, Complaints or Grievances

If you have a concern, complaint or grievance, please contact the Senior Clerical Supervisor, Nursing Supervisor or Clinic Manager before you leave the clinic. You may also contact them through the DOH-Clay operator at 904-529-2800, extension 0, or you may write to them at Health Center Manger, Bear Run Clinic, Florida Department of Health in Clay County, P.O. Box 578, Green Cove Springs, Florida 32043

I have read and understand this summary of clinic operations and expectations. By signing below, I agree to abide by these policies. I understand that clinic services will be provided regardless of my gender, sexual orientation, religion or race.

Patient: _____
Date_____

Witness: _____ Date_____

FLORIDA DEPARTMENT OF HEALTH IN CLAY COUNTY

ADVANCE DIRECTIVES

You have the Right to Decide

All adults in healthcare facilities, such as hospitals, nursing homes, hospice, home health agencies and health maintenance organizations, have certain rights under Florida law. Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

You have the right to file an advance directive, which says, in advance, what kind of treatment you want or do not want when you may have special, serious medical conditions that would stop you from telling your provider how you want to be treated. For example, if you were taken to a healthcare facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment? An advance directive will let the providers know how you want your healthcare to be handled.

What is an advance directive?

An advance directive is a written or oral statement that is made and witnessed in advance of serious illness or injury. It tells others how you want healthcare (including mental health) decisions made when you are not able to make them yourself. There are two forms of an advance directive:

1. a living will
2. a healthcare surrogate designation

An advance directive allows you to state your choices about healthcare, or to name someone to make those choices for you, if and when you become unable to make decisions about your healthcare treatment for yourself. An advance directive can enable you to make decisions about your future healthcare treatment.

What is a living will?

A living will generally states the kind of healthcare you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you still are living. Florida's law provides a suggested form to use for a living will. You may use it or some other form. You may wish to speak to an attorney or provider to be certain you have completed the living will so that your wishes will be understood.

What is a healthcare surrogate designation?

A healthcare surrogate designation is a signed, dated and witnessed paper naming another person—such as a husband, wife, daughter, son or close friend—as your agent. This person will be the one who will make healthcare decisions for you if you should become unable to make them for yourself.

You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form to use for the designation of a healthcare surrogate. You may use it or some other form. You may wish to name a second person as a backup to stand in if your first choice is not available.

You may wish to have both a living will and a healthcare surrogate designation, or you may want to combine them into a single document that describes treatment choices in a variety of situations and names someone to make healthcare decisions for you should you be unable to make these decisions for yourself.

Do I have to write an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive or designated a healthcare surrogate, healthcare decisions may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative or a close friend, in that order. This person would be called a "proxy."

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. One of the witnesses may be a spouse or a blood relative.

Can I change my mind after I write a living will or designate a healthcare surrogate?

Yes, you may change or cancel these documents anytime. Any change should be written, signed and dated. You also can change an advance directive by oral statement.

What if I have filled out an advance directive in another state and need treatment in a healthcare facility in Florida?

An advance directive completed in another state, in compliance with the other state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

Make sure that someone, such as your provider, lawyer, or family member, knows that you have an advance directive and where it is located. Consider the following:

- If you have designated a healthcare surrogate, give a copy of the written designation form or the original to that person.
- Give a copy of your advance directive to your provider for your healthcare file.
- Keep a copy of your advance directive in a place where it can easily be found.
- Keep a card or note in your purse or wallet stating that you have an advance directive and where it is located.

If you change your advance directive, make sure your provider, lawyer and/or family member has the latest copy. Please note you have the right to choose a new healthcare provider in situations when a healthcare provider cannot honor the advance directive wishes of his or her patients because of objections of conscience. For more information, ask those in charge of your care.

Are you interested in an Advanced Directive? Yes_____ No_____

Advanced Directive given? Yes_____ No_____

_____ _____

Patient Signature Date

_____ _____

Clerk Signature Date

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____ (initial) I have a terminal condition,
or _____ (initial) I have an end-stage condition,
or _____ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional Instructions (optional):
_____
_____
_____
_____

(Signed) _____

Witness _____Witness_____
Street Address _____ Street Address _____
City _____ State _____ City _____ State_____
Phone _____ Phone _____
At least one witness must not be a husband or wife or a blood relative of the principal

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Florida Department of Health of Clay County Phone #: 904-272-3177

Address: P.O. Box 578 Green Cove Springs, FL 32043-0578 Fax #: 904-529-2802

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Person/Facility: _____ Phone #: _____

Other method of communication: Cell Phone: _____ Cell Provider: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Records(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of tests(s)) _____

_____ Other: (specify) **Coded text message for Chlamydia and/or gonorrhea results.**

I specifically authorize release of information relating to: (initial selection)

_____ HIV test results for non-treatment purposes _____ Substance Abuse Service Provider Client Records

_____ Psychiatric, Psychological or Psychotherapeutic notes _____ Early Intervention _____ WIC

PURPOSE OD DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client / Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____

☐ **Declined** ☐ **See Previous authorization dated** _____

☐ **Screen only, NO Treatment** ☐ **Provider:** _____

☐ **Treated with:** _____ ☐ **Initials / Date:** _____